MICHIGAN DEPARTMENT OF COMMUNITY HEALTH

DATA CLARIFICATIONS FOR THE 837 PROFESSIONAL CLAIM, VERSION 4010

March 4, 2002

Michigan Department of Community Health

MDCH

MSA MEDICAL SERVICES ADMINISTRATION

This document is intended as a companion to the **National Electronic Data Interchange Transaction Set Implementation Guide, Health Care Claim: Professional Claim, ASC X12N 837 (004010X098)**, dated May 2000. It contains data clarifications authorized by the Department of Health and Human Services on September 17, 2001. The clarifications include:

- identifiers to use when a national standard has not been adopted [and]
- parameters in the implementation guide that provide options

(The implementation guide can be found at http://www.wpc-edi.com/hipaa/hipaa_40.asp. HHS guidance on data clarifications can be found at http://aspe.os.dhhs.gov/admnsimp/q0321.htm.)

Page	Loop	Segment	Data Element	Comments
66		REF – Transmission Type Identification	REF02 – Transmission Type Code	Use “004010X098” if using May 2000 Implementation Guide.
69	1000A – Submitter Name	NM1	NM109 – Submitter Identifier	Use the 4-character billing agent ID assigned by MDCH.
75	1000B – Receiver Name	NM1	NM109 – Receiver Primary Identifier	Use “D00111” for MDCH.
86	2010AA – Billing Provider Name	NM1	NM108 – Identification Code Qualifier	Use “24” or “34”.
			NM109 – Billing Provider Identifier	Use the same EIN or SSN value assigned to MDCH provider identifier used in REF02 of this loop.
92		REF – Billing Provider Secondary Identification	REF01 – Reference Identification Qualifier	Use “1D”.
			REF02 – Billing Provider Additional Identifier	Use the 9-digit provider identifier assigned by MDCH (2-digit provider type followed by 7-digit assigned ID).
108	2000B - Subscriber Hierarchical Level	HL		MDCH accepts a maximum of 5000 CLM segments in a single transaction (ST-SE) as recommended by the HIPAA-mandated implementation guide.
110		SBR – Subscriber Information	SBR01 – Payer Responsibility Sequence Number Code	Use “P” if MDCH is the only payer (that is, patient has no Medicare or other insurance), “S” if there is one other payer, or “T” if there are two or more other payers.
112			SBR09 – Claim Filing Indicator Code	Use “MC” for Michigan Medicaid, “TV” for CSHCS (Title V), or “11” for State Medical Plan (Other Non-Federal). If recipient qualifies for more than one program, or other MDCH program not listed, use “MC”.
119	2010BA – Subscriber Name	NM1	NM108 – Identification Code Qualifier	Use “MI”.
			NM109 – Subscriber Primary Identifier	Use the patient’s 8-digit member ID number assigned by MDCH.
131	2010BB – Payer Name	NM1	NM108 – Identification Code Qualifier	Use “PI”.

Page	Loop	Segment	Data Element	Comments
			NM109 – Payer Identifier	Use "D00111" for MDCH.
170	2300 – Claim Information	CLM		Note that the HIPAA-mandated implementation guide allows a maximum of 100 repetitions of the 2300 CLM loop within each patient/subscriber loop.
173			CLM05-3 – Claim Frequency Code	Use "1" on original claim submissions. Use "7" for claim replacement (and show original CRN as indicated on page 229).
212		DTP – Date – Assumed and Relinquished Care Dates		MDCH requires this on claims to indicate "assumed care date" and "relinquished care date" for situations where providers share post-operative care. When a surgeon submits the claim, "091" is used in DTP01 to show the date care was relinquished to another physician. When the second physician submits that claim, "090" is used to indicate the date care was assumed for the patient.
228		REF – Prior Authorization Number	REF01 – Reference Identification Qualifier	Use "G1".
			REF02 – Prior Authorization Number	Use the 9-digit number assigned by MDCH.
230		REF – Original Reference Number (ICN/DCN)	REF01 – Reference Identification Qualifier	When submitting a claim replacement (as indicated by CLM05-3), use "F8".
			REF02 – Claim Original Reference Number	Use the 10-digit CRN assigned by MDCH to the last approved claim.
265		HI – Health Care Diagnosis Code	HI01 – Principal Diagnosis	MDCH requires this element on every claim.
288	2310A – Referring Provider Name	REF – Referring Provider Secondary Identification	REF01 – Reference Identification Qualifier	Use "1D".
			REF02 – Referring Provider Secondary Identifier	Use the 9-digit provider identifier assigned by MDCH (2-digit provider type followed by 7-digit assigned ID).
290	2310B – Rendering Provider Name			This loop will normally not be used, since MDCH requires each practitioner's Medicaid-assigned ID in the billing provider loop (page 92). In the case where a substitute (locum tenens) was used, that person should be entered here.

Page	Loop	Segment	Data Element	Comments
292		NM1 – Rendering Provider Name	NM108 – Identification Code Qualifier	Use “24” or “34”.
			NM109 – Rendering Provider Identifier	Use the same EIN or SSN value assigned to MDCH provider identifier used in REF02 of this loop.
296		REF – Rendering Provider Secondary Identification	REF01 – Reference Identification Qualifier	Use “1D”.
297			REF02 – Rendering Provider Secondary Identifier	Use the 9-digit provider identifier assigned by MDCH (2-digit provider type followed by 7-digit assigned ID).
319	2320 – Other Subscriber Information	SBR – Subscriber Information		If the patient has Medicare or other insurance, repeat this loop for each other payer. Do not put information about MDCH coverage in this loop.
			SBR01 – Payer Responsibility Sequence Number Code	If the patient has Medicare, report that coverage with code “P” and any other insurance with codes “S” or “T” as appropriate. If the patient does not have Medicare, report each coverage with code “P”, “S”, or “T” as appropriate.
			SBR02 – Individual Relationship Code	The code carried in this element is the patient’s relationship to the person who is insured. For example, if a child with Medicaid also has coverage under the father’s insurance, use code “19” (Child).
320			SBR03 – Insured Group or Policy Number	Use the subscriber’s group number (assigned by the other payer), not the number that uniquely identifies the subscriber. For example, group numbers assigned by BCBSM are usually 5 digits.
321			SBR05 – Insurance Type Code	Do not use “MC” in this element.
			SBR09 – Claim Filing Indicator Code	Do not use “MC” or “TV” in this element.
350	2330A – Other Subscriber Name	NM1	NM103, NM104, NM105, NM107 – Other Insured Last Name, First Name, Middle Name, Suffix	Use the name of the subscriber as it appears on the files of the other payer.

Page	Loop	Segment	Data Element	Comments
352			NM108 – Identification Code Qualifier	Use “MI”.
			NM109 – Other Insured Identifier	Use the unique member number assigned to the subscriber by the other payer indicated in loop 2330B. For example, member numbers assigned by BCBSM are usually 3 letters followed by 9 digits.
357		REF – Other Subscriber Secondary Identification	REF01 – Reference Identification Qualifier	Do not use “1W”.
360	2330B – Other Payer Name	NM1	NM108 – Identification Code Qualifier	Use “PI”.
361			NM109 – Other Payer Primary Identifier	Use the carrier code assigned by MDCH (see MDCH website for listing of carrier codes). For example if BCBSM Traditional was the Other Payer, the value (carrier code) carried in this element would be 00029005.
380	2330D – Other Payer Referring Provider	REF – Other Payer Referring Provider Identification	REF01 – Reference Identification Qualifier	Do not use “1D”.
384	2330E – Other Payer Rendering Provider	REF – Other Payer Rendering Provider Secondary Identification	REF01 – Reference Identification Qualifier	Do not use “1D”.
388	2330F – Other Payer Purchased Service Provider	REF – Other Payer Purchased Service Provider Identification	REF01 – Reference Identification Qualifier	Do not use “1D”.
392	2330G – Other Payer Service Facility Location	REF – Other Payer Service Facility Location Identification	REF01 – Reference Identification Qualifier	Do not use “1D”.
396	2330H – Other Payer Supervising Provider	REF – Other Payer Supervising Provider Identification	REF01 – Reference Identification Qualifier	Do not use “1D”.

Page	Loop	Segment	Data Element	Comments
554	2430 – Line Adjudication Information			MDCH expects this loop for each payer identified in loop 2320, except when that payer has adjudicated this claim at the claim level.